Mail or fax completed application to:

DEPARTMENT OF HEALTH AND HOSPITALS
Children's Special Health Services

Date received by CSHS office: ______________
OPH ID: ______________

Application for Children's Special Health Services

A note from the child's health care provider (doctor or nurse practitioner) with the child/youth's suspected diagnosis or health condition should come with this form. Any of the following will be accepted—(1) have the health care provider complete Section 5 of this form; (2) attach a note from the health care provider with this information; (3) have the health provider mail or fax a note with this information to CSHS.

1. Where did you get this application?

☐ Doctor's office ☐ Hospital ☐ Parish Health Unit or CSHS ☐ Internet
☐ School Nurse ☐ Health Fair ☐ Neighborhood Place ☐ Other: ______

SECTION 1 – APPLICANT & HOUSEHOLD INFORMATION

2. Tell us about the child applying to CSHS.

Name (First, MI, Last): ____

Date of Birth (month/day/year): ______/_______/_________ Sex: ☐ Female ☐ Male

Social Security Number (SSN): _________-_______-_________ *Write "NONE" if child does not have a SSN*

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Choose not to reply

Race*:* ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White
☐ Native Hawaiian/Pacific Islander ☐ More than one race ☐ Choose not to reply

Louisiana Resident? ☐ Yes ☐ No (please explain): ______________________________

3. Tell us about the child's parent/guardian.

(*If you are a youth over age 18* ***AND*** *do not live with your parents, start at "Home address."***)**

Name (First, MI, Last): ____

Relationship to child: ____

Home address: _______________________City: ___________________ State: _______ Zip: _________

Mailing address: _____________________City: ___________________ State: _______ Zip: _________

Home # ( ) ____________________ Work # ( ) ____________________

Cell # ( ) ____________________ E-mail: ______________________________

What day, time and phone number is best to reach you Mon-Fri from 8 AM-4:30 PM?

Day: _______________ Time: ___________________________ Phone: ☐ Home ☐ Work ☐ Cell

4. Tell us about the child's other parent/guardian who does not live in the child's household.

(*If no other parent/guardian* ***OR*** *if you are a youth over age 18* ***AND*** *do not live with your parents, skip to question #5.***)**

Name (First, MI, Last): ____

Relationship to child: ____

Home # ( ) ____________________ Work # ( ) ____________________

Cell # ( ) ____________________ E-mail: ______________________________

5. How many people live in the household? ______

SECTION 2 – FINANCIAL & INSURANCE INFORMATION

6. Check all benefits the child currently receives that are listed below.

☐ Medicaid or Bayou Health ☐ Medicare ☐ LaCHIP ☐ TriCare (Military) ☐ Private insurance ☐ No insurance

Note: *If you check an item above, you must provide documentation at the first clinic visit.*

You do not need to answer this question if the child has Medicaid/LaCHIP/Bayou Health; skip to Question # 8

7. What is the total monthly income for all household members? This includes work and income from any of the following:

Social Security	Workman's Compensation	Alimony	Other
Child Support	Military family allotment	Retirement/Pension/Annuities	
Veteran's benefits	Interest/Dividends/Royalties	Refugee cash assistance	

Total Income: $ _______________

Note: *You must provide documentation for all income at the first clinic visit. In addition, you must also provide documentation of any of the following assets:*

Checking account	Stocks/bonds	Property (other than home)	Savings account
Certificates of deposit	Retirement accounts	Annuities/trusts	Share in estate
Lump sum settlement	Vehicles (if more than 2)	Promissory note	

SECTION 3 – DISABILITY & HEALTH CARE INFORMATION

8. What is the child's diagnosis or disability? ____

9. Tell us about the doctors who have provided care in the last 2 years for the child's diagnosis or disability that was entered in Question 8.

Doctor's name	Doctor's address	Doctor's phone #

10. Has the child ever received any services from a parish public health unit in Louisiana?

☐ No ☐ Yes → Enter the name of the parish(es): ____

SECTION 4 – CONTACT INFORMATION

11. List the names of friends, relatives or co-workers we may call if we cannot contact you.

Name	Relationship to you	Phone number(s)

- I am applying to CSHS for assistance for the child named in Question 2. The information I have given on this application is true and correct to the best of my knowledge.
- I agree to let CSHS get the information needed to verify the child's medical and financial situation. If I refuse to help with this process, it will mean that the child cannot receive services from CSHS until I do help.

____ ____________________________

Signature **Date**

Parent/Legal guardian **or** Youth over 18 years of age
or Agency Representative/Title/Agency (if child/youth is in custody of this agency)

SECTION 5 – DIAGNOSIS CONFIRMATION TO BE COMPLETED BY PHYSICIAN or NURSE PRACTITIONER

Please verify the child's diagnosis or suspected health condition by completing this section or mailing/faxing a signed note to CSHS with this information.

Diagnosis/Health Condition: ____Date:_________

Signature/Credentials (physician/nurse practitioner):____